2017 Idaho Oral Health Convening

Medical-Dental Collaboration: Focus on Patient-Centered Care

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May 12, 2017
Boise, Idaho

ADA American Dental Association®

NNOHA National Network for Oral Health Access

Objectives

- Describe impact of poor oral health across the lifespan;
- Conceptualize dental-medical collaboration;
- Develop collaborative dental-medical relationships;
- Execute successful, coordinated, bidirectional dental/medical referral;
- Access and use existing tools developed for medical-dental collaboration;
- Describe how oral health promotion in the medical setting impacts patients.

The Big Picture

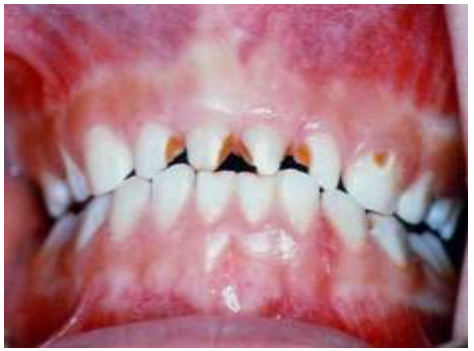
"You are not healthy without good oral health…"

C. Everett Koop, MD

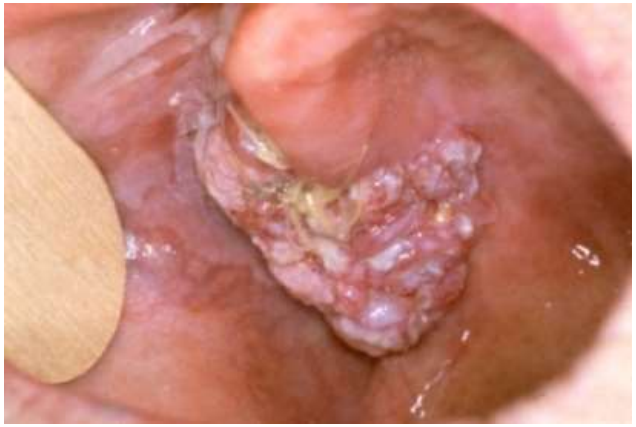
- Dental care: the most common unmet health need
- Oral disease can severely affect systemic health
- Profound disparities in oral health and access to care exist at all ages
- Much oral disease is preventable or at least controllable

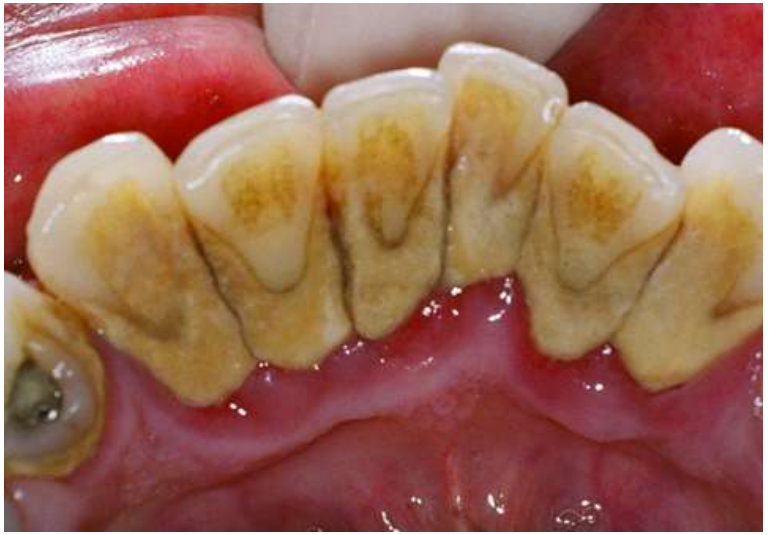
Prevalence of oral disease

- Dental caries is the most common chronic disease of childhood
  - 5 times more common than asthma
  - Affects 50% of low income children
  - Affects 70% of Native American children



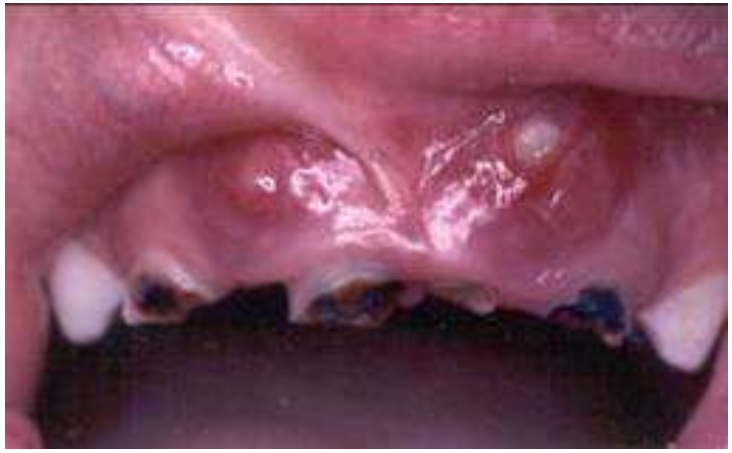
- Severe gum disease affects 19% of adults aged 25-44
- 45,000 oral/pharyngeal cancers diagnosed annually
  - 1 person dies every hour
  - Diagnosis is often late

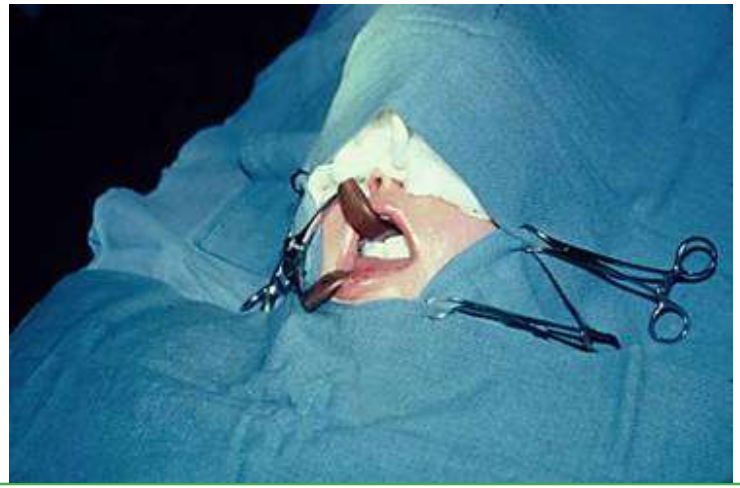




Physical, Economic and Social Consequences

- Mounting evidence of **aggravating effects on systemic conditions**
- **Oral pain**
  - Poor school performance in children
  - Work loss in adults
  - Poor chewing and poor nutrition
  - Costly emergency department visits
- **Dental decay and tooth loss**
  - Aesthetics and self-image
  - Speech and language development
  - Costly restoration…operating room!





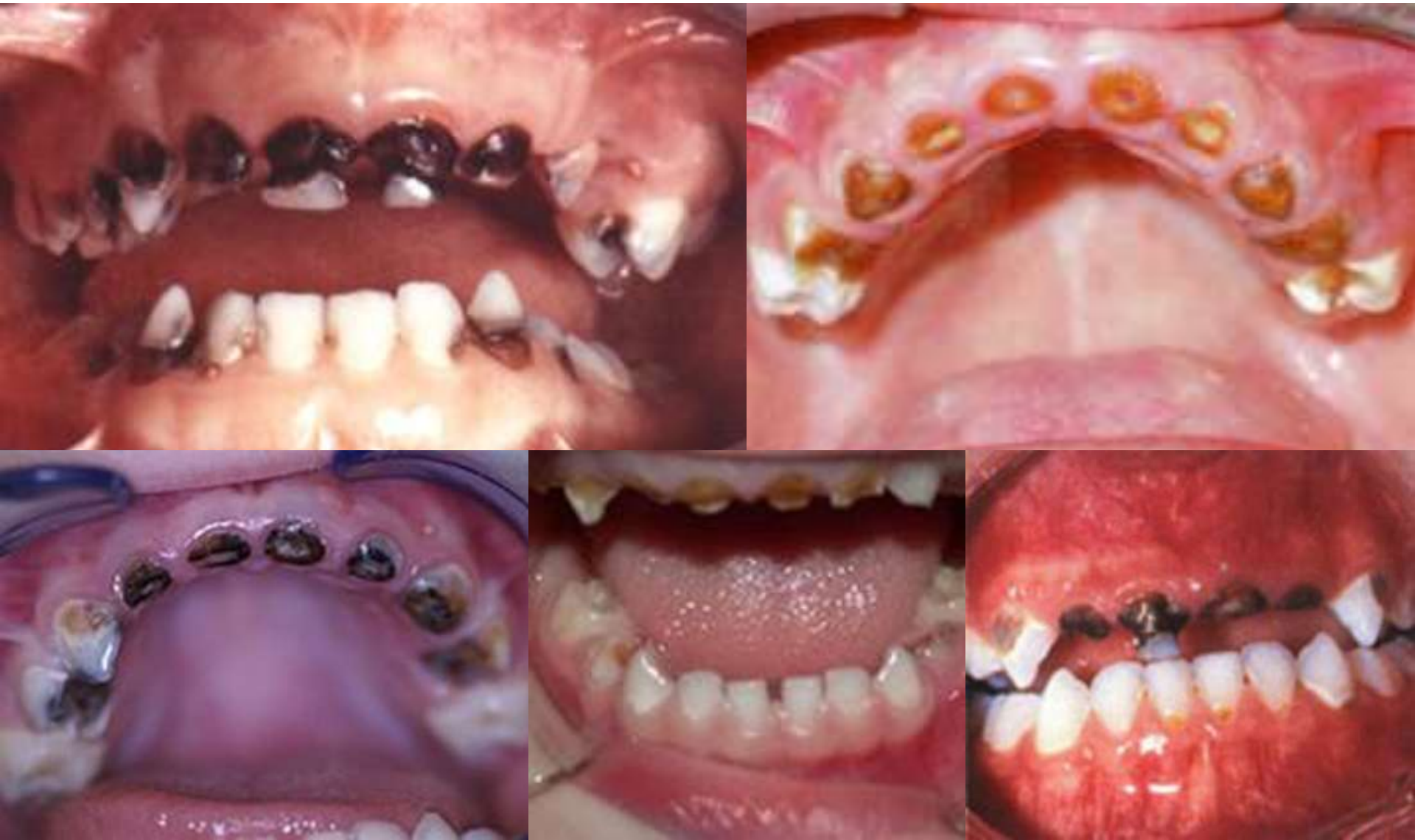
Prevalence of Geriatric Oral Health Issues

- 50% of the elderly (age >65) perceive their dental health as poor or very poor
- 33% of the elderly had untreated tooth decay.
- Low income elderly suffer more severe tooth loss than their wealthy counterparts
- Edentulism: 1/3 of those >age 65; 50% in nursing homes
- Periodontitis in 41% of the elderly
- Only 30% have dental insurance
- No oral health benefits in Medicare

Importance of Putting the Pieces Together

Why is Oral Health Important?...a case study

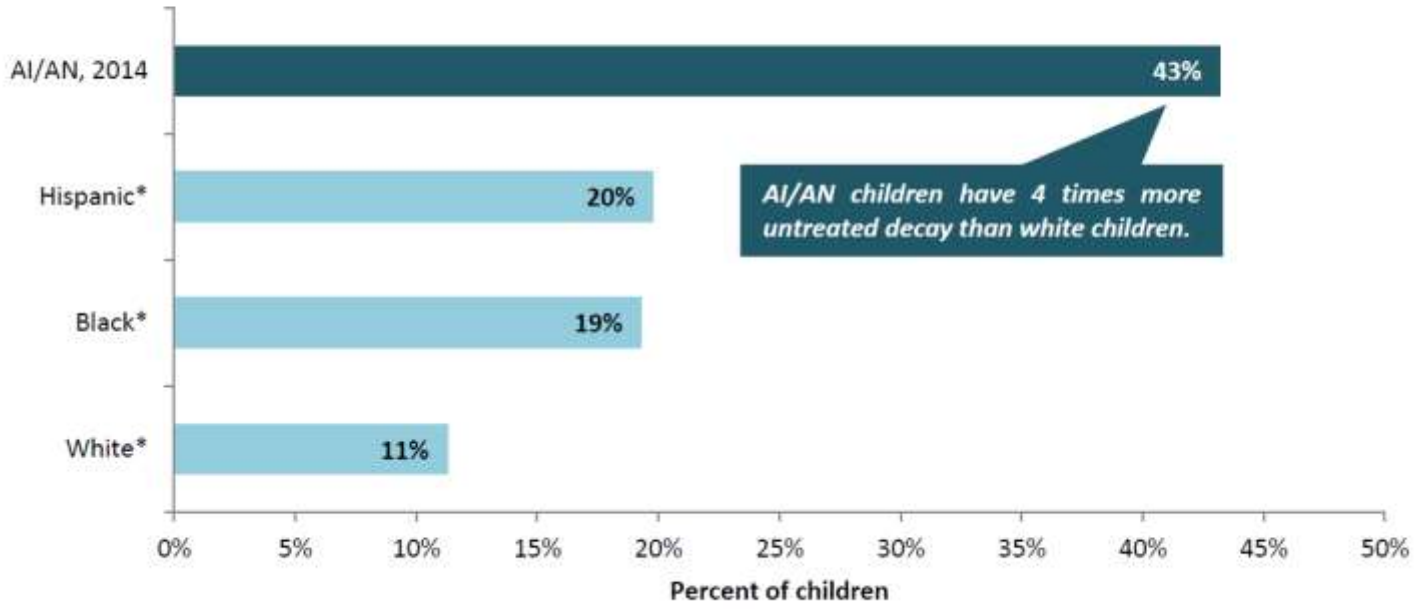
Disease burden overwhelming…



Untreated decay in children by comparison

Indian Health Service Data Brief ❖ April 2015

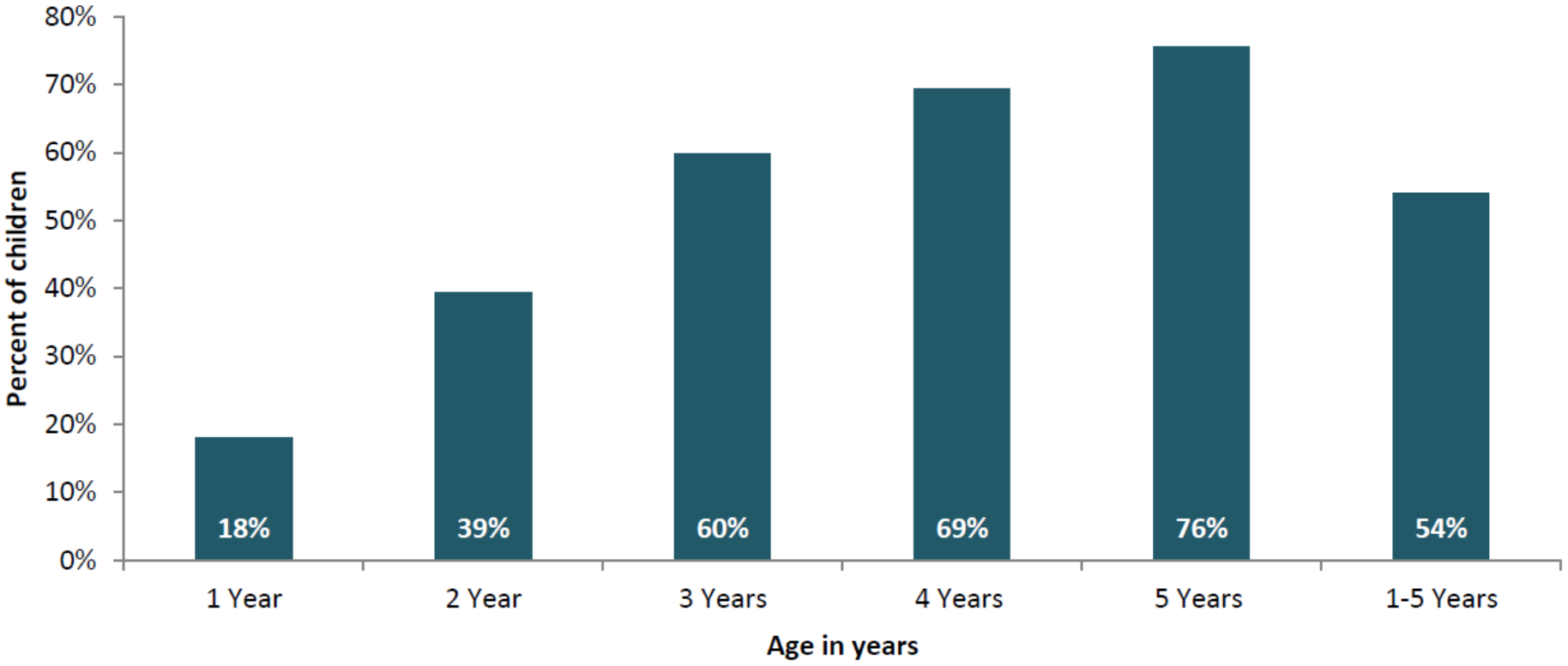
Figure 2. Percent with untreated decay among children 3-5 years of age

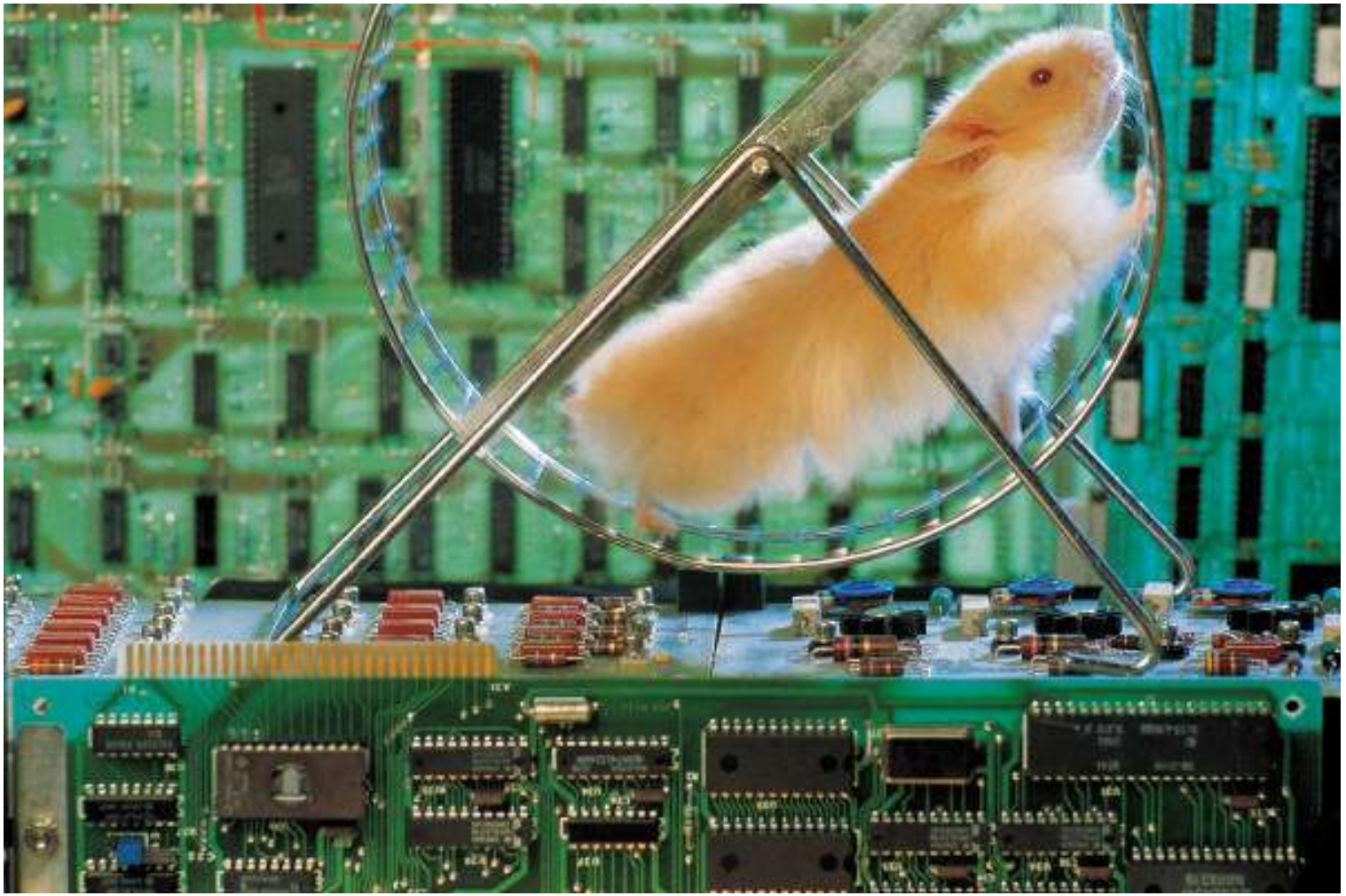


* Data Source: National Health and Nutrition Examination Survey (NHANES), 2009-2010

Decay experience in AI/AN children

Figure 3. Prevalence of decay experience in the primary teeth of AI/AN children by age, 2014



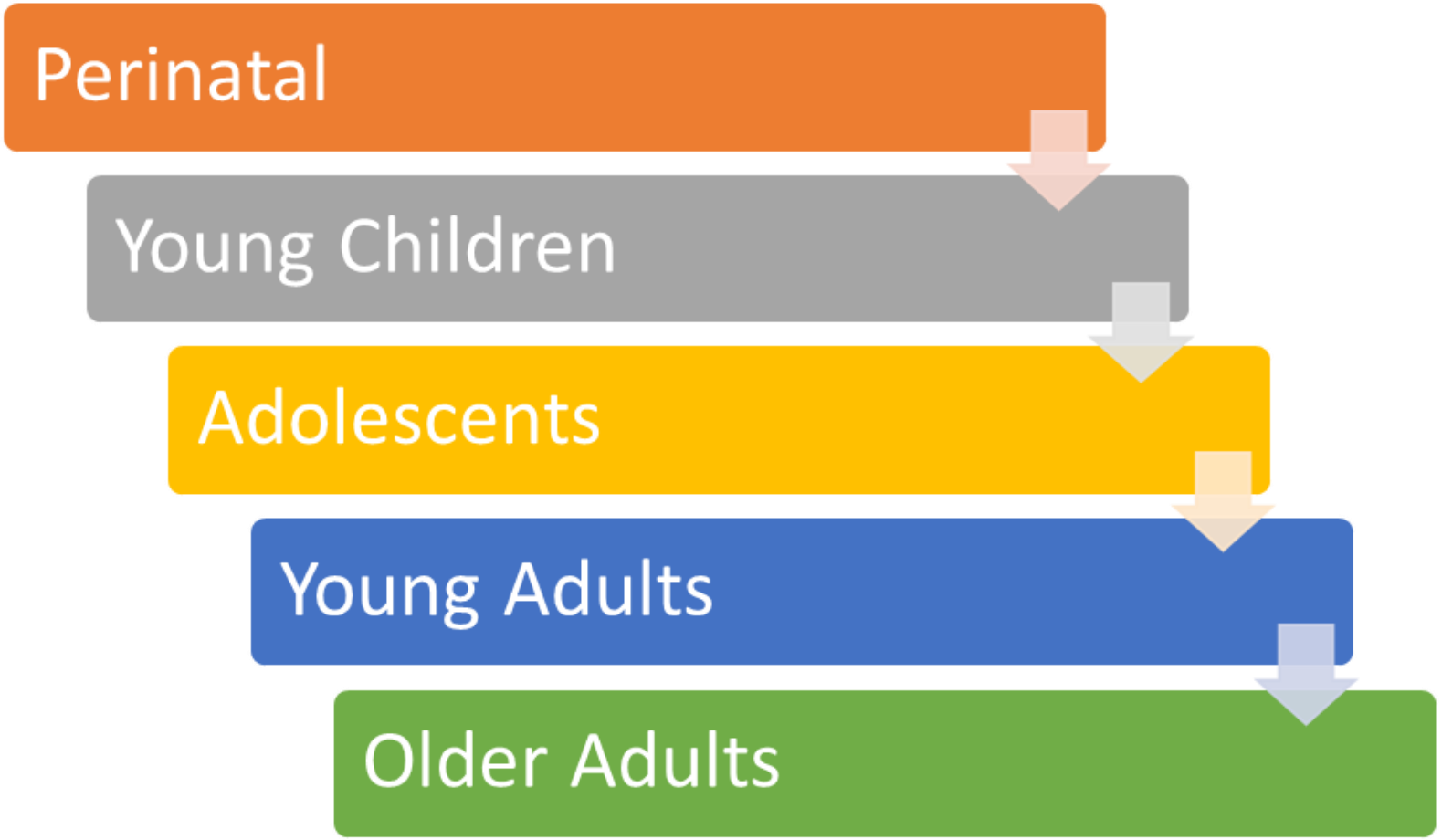


“Insanity: doing the same thing over and over again and expecting different results.”

Albert Einstein

Prevention matters…individually and community-wide

Working across the lifespan



Practical Goals across the Lifespan…

- Every individual will have access to the benefits of fluoride.
- Every pregnant woman will have a healthy mouth.
- Every child will be caries-free upon entering kindergarten.

Practical Goals across the Lifespan…

- Every person with a chronic disease, such as diabetes or HIV, will receive oral health care as an integral part of their disease management.
- Every senior will have access to dentures or other replacement options.

Where do we start?

What do we already have going?

Collaboration is about:

- understanding others
- educating others about your positions
- correcting misconceptions about your positions
- **developing trust**
- working with others in search of common ground
- having input in decisions made outside your organization
- taking an honest look at your own beliefs.

Supporting Dental-Medical Collaboration

Dental Concerns Across the Lifespan

No Oral Health Coverage

- 130 million Americans
  - 1 out of 5 children
  - 2 out of 5 adults
  - 7 out of 10 seniors

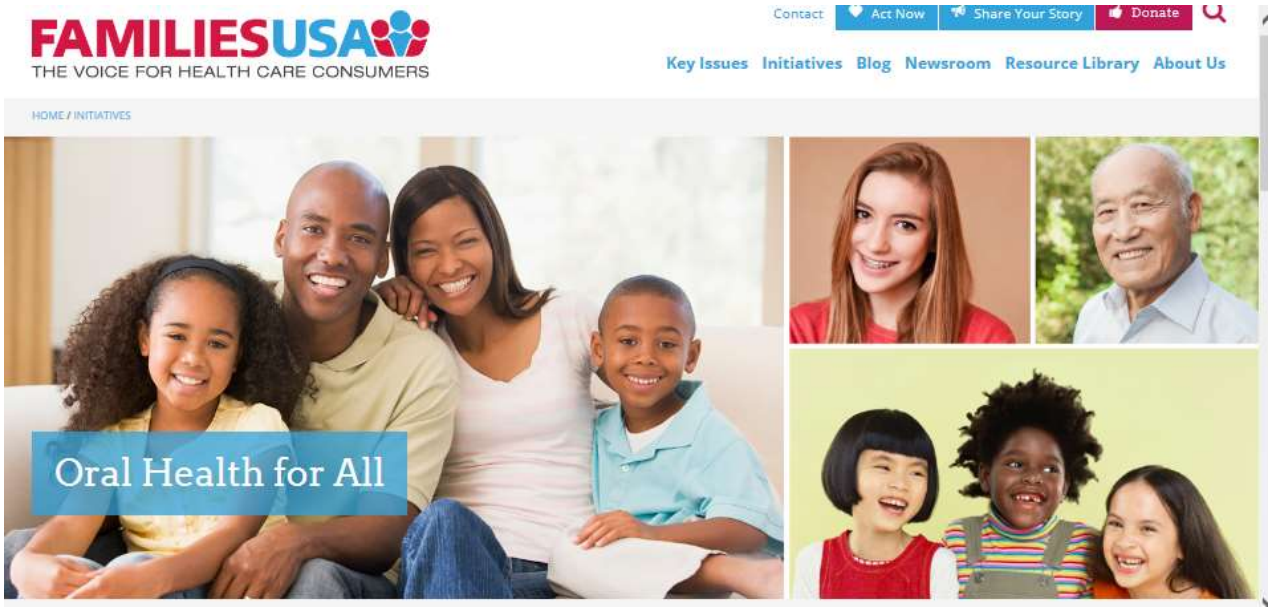
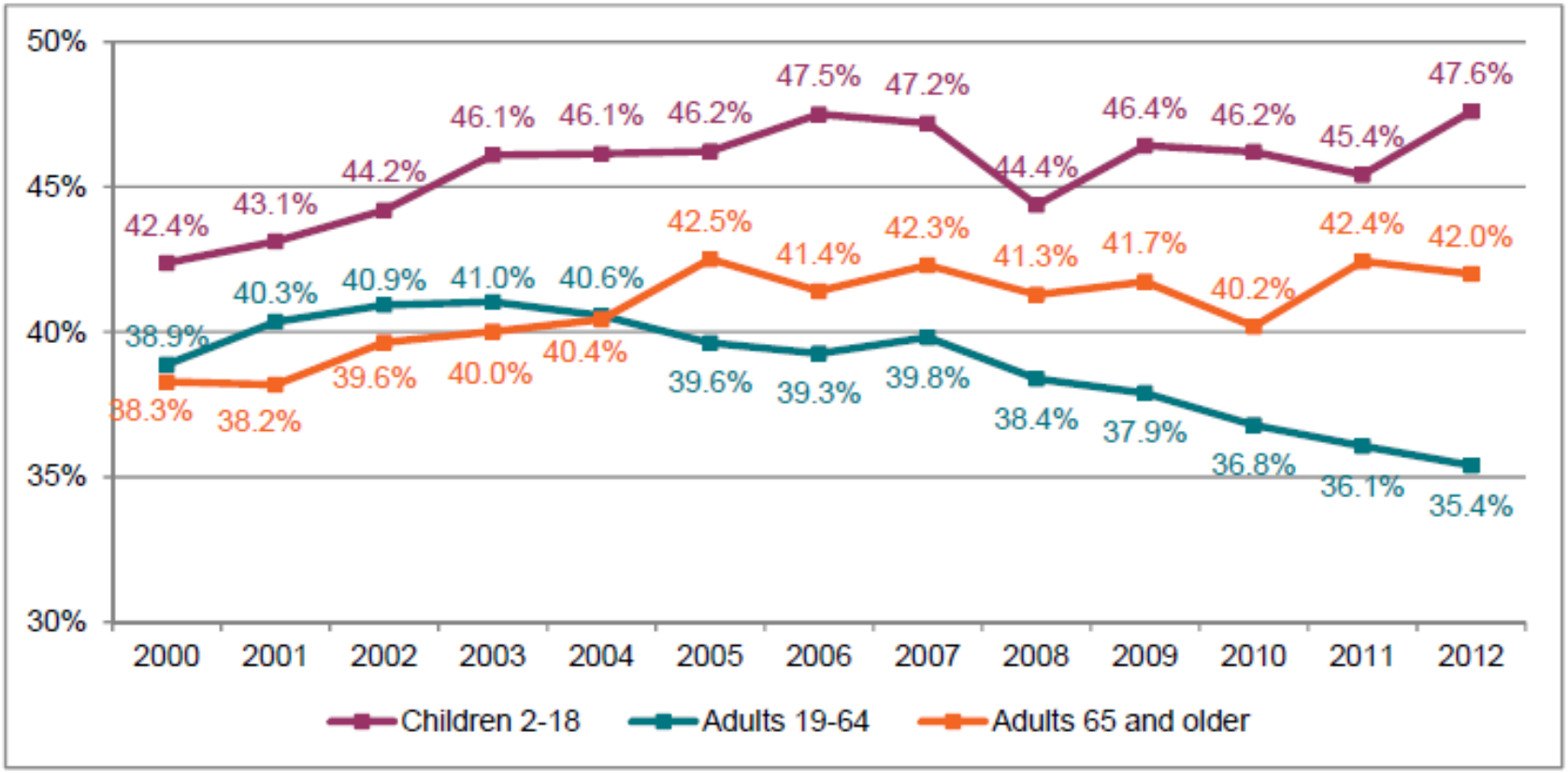


Figure 1: Percentage of the Population with a Dental Visit in the Year, 2000-2012



Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** For children ages 2-18, changes were statistically significant at the 1% level (2000-2012) and at the 10% level (2011-2012). Among adults ages 19-64, changes were statistically significant at the 1% level (2003-2011). For adults 65 and older, changes were significant at the 5% level (2000-2012). Changes from 2011 to 2012 among adults 19-64 and the elderly 65 and above were not statistically significant.

Figure 2: Percentage of the Population with a Dental Visit in the Year for Select Age Groups, 2000-2012

Leverage the Medical Visit

Integration of Oral Health and Primary Care Practice

Department of Health and Human Services
Health Resources and Services Administration
February 2014

https://bphc.hrsa.gov/qualityimprovement/clinicalquality/oralhealth/

HRSA recommendations…

1. Apply **oral health core clinical competencies** within primary care practices to increase oral health care access for safety net populations.

2. **Develop infrastructure that is interoperable, accessible across clinical settings**, and enhances adoption of the oral health core clinical competencies. The defined, essential elements of these competencies should be used to inform decision-making and measure health outcomes.

3. **Modify payment policies** to efficiently address costs of implementing these competencies and provide incentives to health care systems and practitioners.

4. Execute programs to **develop and evaluate implementation strategies** of these competencies into primary care practice

Domains…a starter set

- Risk Assessment
- Oral Health Evaluation
- Preventive Intervention
- Communication and Education
- Interprofessional Collaborative Practice

Oral health is essential for overall health

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

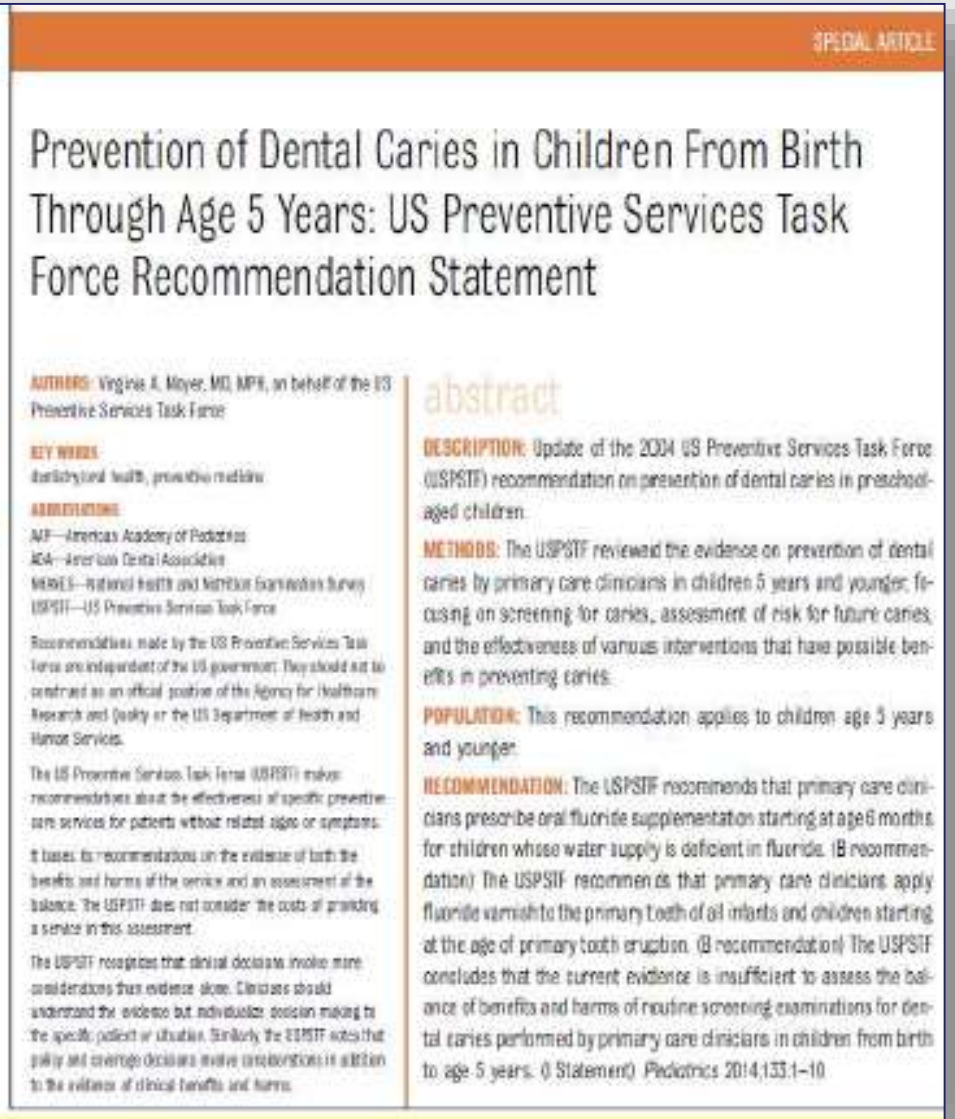
Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision		●	●	●	●	●	●	●	●	●	●	●	●	●[7]	●	●	●	●	●	●	●	★	●	★	●	★	●	★	●	★	●	★
Hearing		●[8]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																
Developmental Screening[9]								●			●		●																			
Autism Screening[10]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[12]																						●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																																
Newborn Blood Screening[15]		◄———	●	———►																												
Critical Congenital Heart Defect Screening[16]		●																														
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★	★	★															
Tuberculosis Testing[21]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]												★			★		★		★	◄———	●	———►	★	★	★	★	★	◄———	●	———►	★
STI/HIV Screening[23]																						★	★	★	★	★	◄———	●	———►	★	★	★
Cervical Dysplasia Screening[24]																																●
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●			●															
Fluoride Varnish[26]							◄———				●	———►																				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/6/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. If the patient is uncooperative, rescreen within 6 months, per the 2007 AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/111/4/902.abstract).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally undressed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendeduniformscreening.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/state/genes-r-us/filesh/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: http://redbook.aappublications.org/site/resources/Inschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.
18. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/125/5/1040.full).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/129/5/1003.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full), 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/cgi/doi/10.1542/peds.2014-1699), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children (http://pediatrics.aappublications.org/content/134/6/1224.full)."
26. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspschdv.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/cgi/doi/10.1542/peds.2014-1699).

U.S. Preventive Services TASK FORCE



SPECIAL ARTICLE

Prevention of Dental Caries in Children From Birth Through Age 5 Years: US Preventive Services Task Force Recommendation Statement

AUTHORS: Virginia A. Moyer, MD, MPH, on behalf of the US Preventive Services Task Force

KEY WORDS
dental/oral health, preventive medicine

ABBREVIATIONS
AAP—American Academy of Pediatrics
ADA—American Dental Association
NHANES—National Health and Nutrition Examination Survey
USPSTF—US Preventive Services Task Force

Recommendations made by the US Preventive Services Task Force are independent of the US government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the US Department of Health and Human Services.

The US Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific preventive care services for patients without related signs or symptoms.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

abstract

DESCRIPTION: Update of the 2004 US Preventive Services Task Force (USPSTF) recommendation on prevention of dental caries in preschool-aged children.

METHODS: The USPSTF reviewed the evidence on prevention of dental caries by primary care clinicians in children 5 years and younger, focusing on screening for caries, assessment of risk for future caries, and the effectiveness of various interventions that have possible benefits in preventing caries.

POPULATION: This recommendation applies to children age 5 years and younger.

RECOMMENDATION: The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. (B recommendation) The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. (B recommendation) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine screening examinations for dental caries performed by primary care clinicians in children from birth to age 5 years. (I Statement) *Pediatrics* 2014;133:1–10

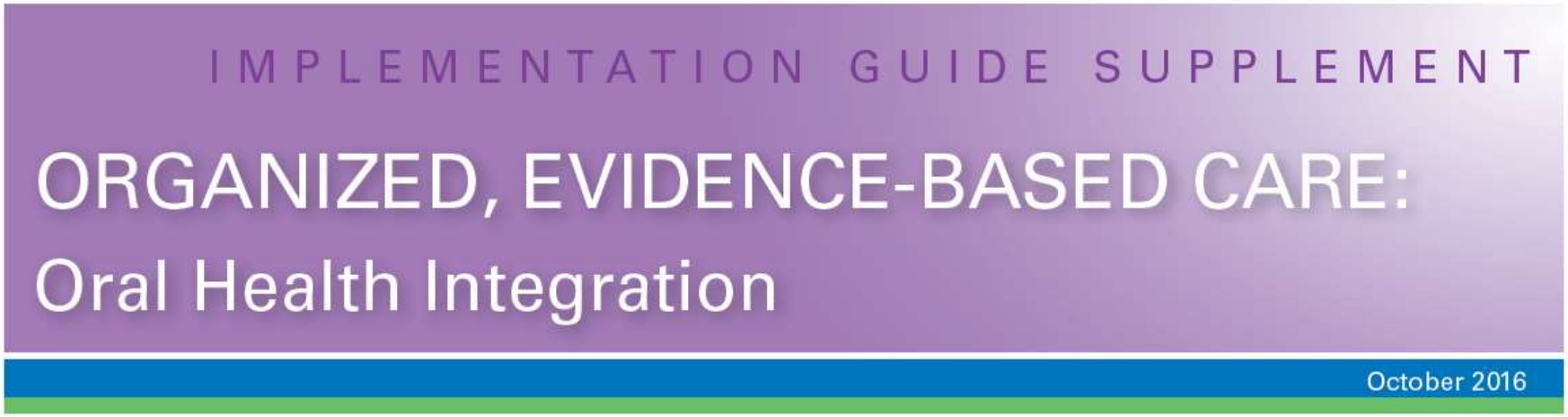
Moyer VA; US Preventive Services Task Force. Prevention of dental caries in children from birth through age 5 years: US Preventive Services Task Force recommendation statement. *Pediatrics*. 2014;133(6): 1102–1111.

Smiles for Life: a national oral health curriculum

Eight annotated educational modules

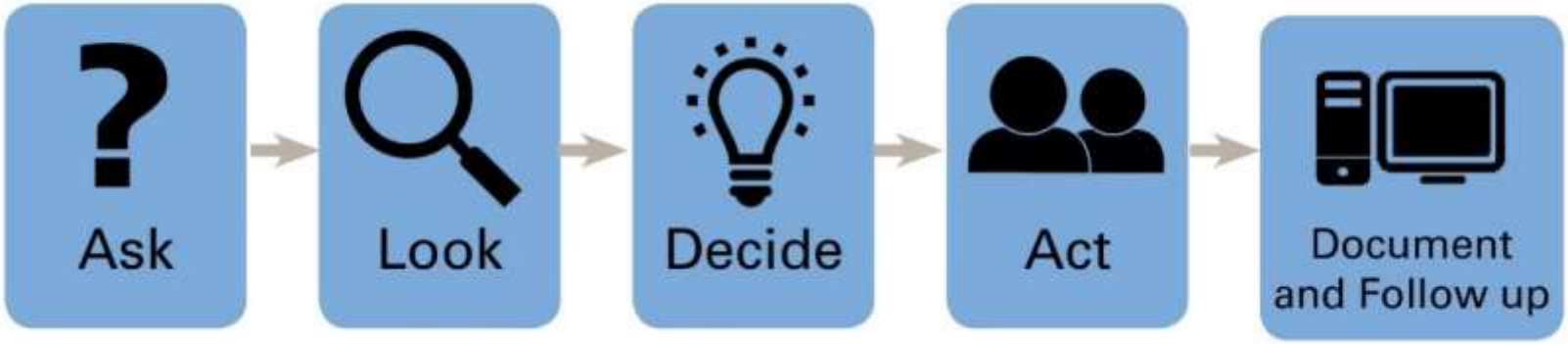
1. The Relationship of Oral to Systemic Health
2. Child Oral Health
3. Adult Oral Health
4. Acute Dental Problems
5. Oral health & the Pregnant Patient
6. Fluoride Varnish
7. The Oral Examination
8. Geriatric Oral Health

http://www.smilesforlifeoralhealth.org



http://www.safetynetmedicalhome.org/sites/default/files/Guide-Oral-Health-Integration.pdf

Oral Health Delivery Framework



Oral Health Delivery Framework

Ask: Symptoms or risks

- Pain, bleeding, burning, dry mouth
- Dietary patterns
- Hygiene
- Time since last dental visit

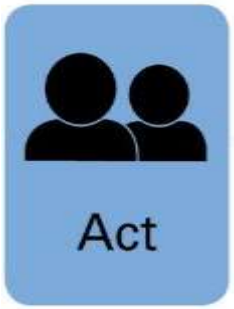
Look: Signs

- Oral hygiene
- Dry mouth
- Obvious caries
- Inflammation
- Exposed roots
- Mucosa abnormalities

Oral Health Delivery Framework

Decide: High risk or not?

Oral Health Delivery Framework



Act: Clinical intervention

- Medication changes
- Oral hygiene training
- Dietary changes
- Fluoride
- Referral to dentistry

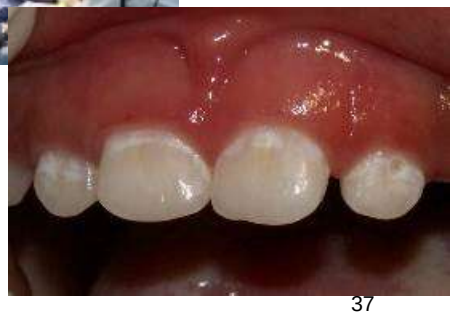
Document and follow-up

- Patient health record
- Referral management
- Information transfer

National *Interprofessional Initiative* on Oral Health

Coordinated Referrals

- Communicate important information
  - Pertinent health history/allergies/Izs
  - Reason for referral (routine, urgent, other)
  - Patient demographics
  - Practice contact information
  - Call me…
  - Bidirectional



2005- Oral Health Disparities Collaborative Pilot Implementation Manual

The Health Resources and Services Administration's Health Disparities Collaboratives
A National Quality Effort to Improve Outcomes for All Medically Underserved People

Oral Health Disparities Collaborative Implementation Manual

1

2015- A User's Guide for Implementation of Interprofessional Oral Health Core Clinical Competencies

A User's Guide for Implementation of Interprofessional Oral Health Core Clinical Competencies: Results of a Pilot Project

NNOHA
National Network for Oral Health Access

Bring theory to reality…

Three pilot health centers each selected a population around which to base their intervention and selected an oral health curriculum for medical staff to be trained in.

The goals were to evaluate if this training leads to:

- Increased oral health screenings and preventive services
- Increased oral health integration and primary care practice
- Increased interprofessional collaborative practice
- Increased care coordination between medical and dental
- Identifiable sustainable approaches to practice changes

Perinatal Oral Health Consensus Statement

Collaboration among:

- American Dental Association
- American Congress of Obstetricians and Gynecologists
- Federal Government

http://mchoralhealth.org/materials/consensus_statement.php

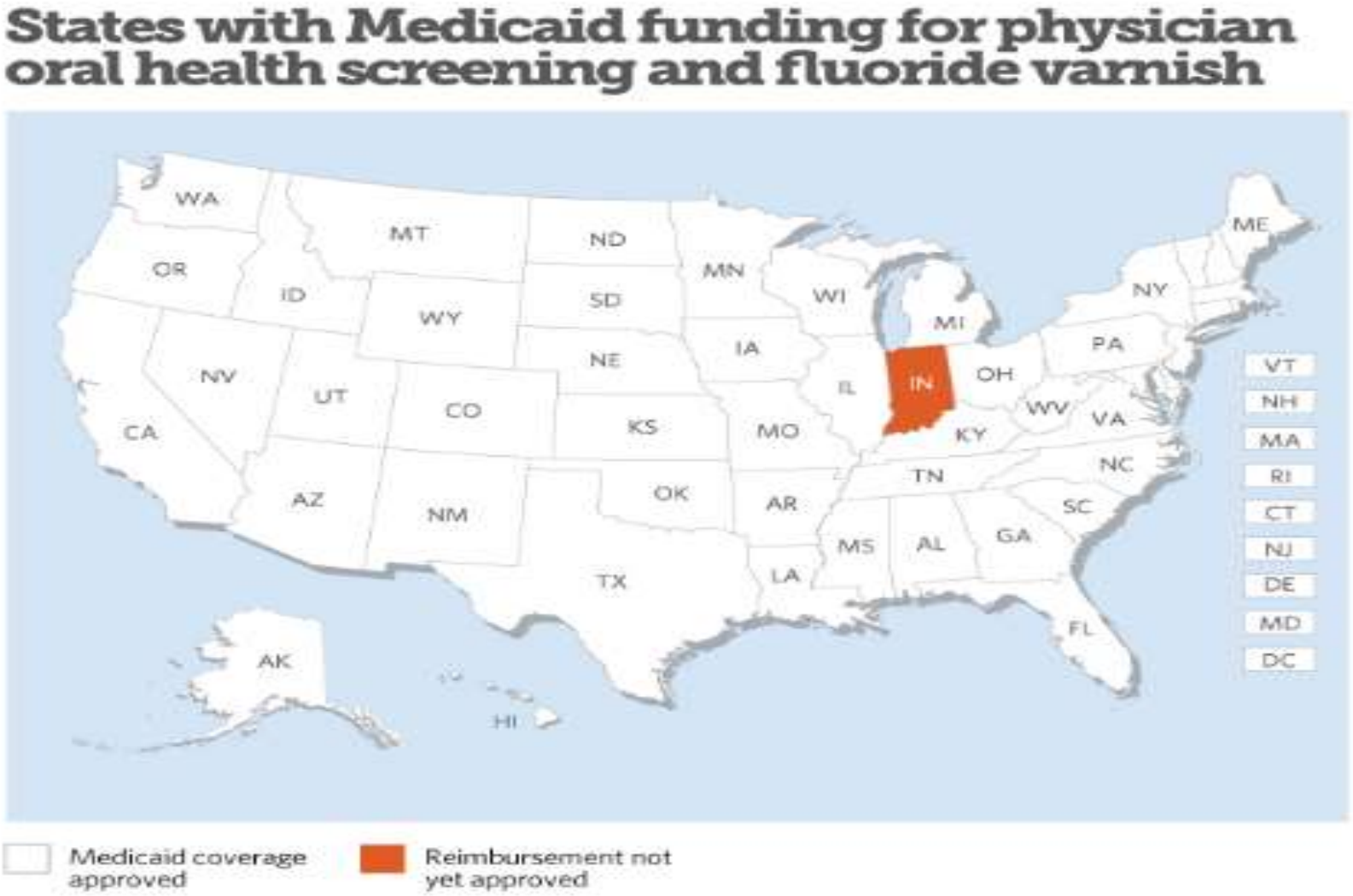
CATOOH

(Chapter Advocacy Training on Oral Health)

- Collaboration between ADA Foundation and American Academy of Pediatrics
- Train the Trainer across all 50 states
  - Caries Risk Assessment
  - Anticipatory Guidance
  - Fluoride Varnish as appropriate
  - Referral to a dentist

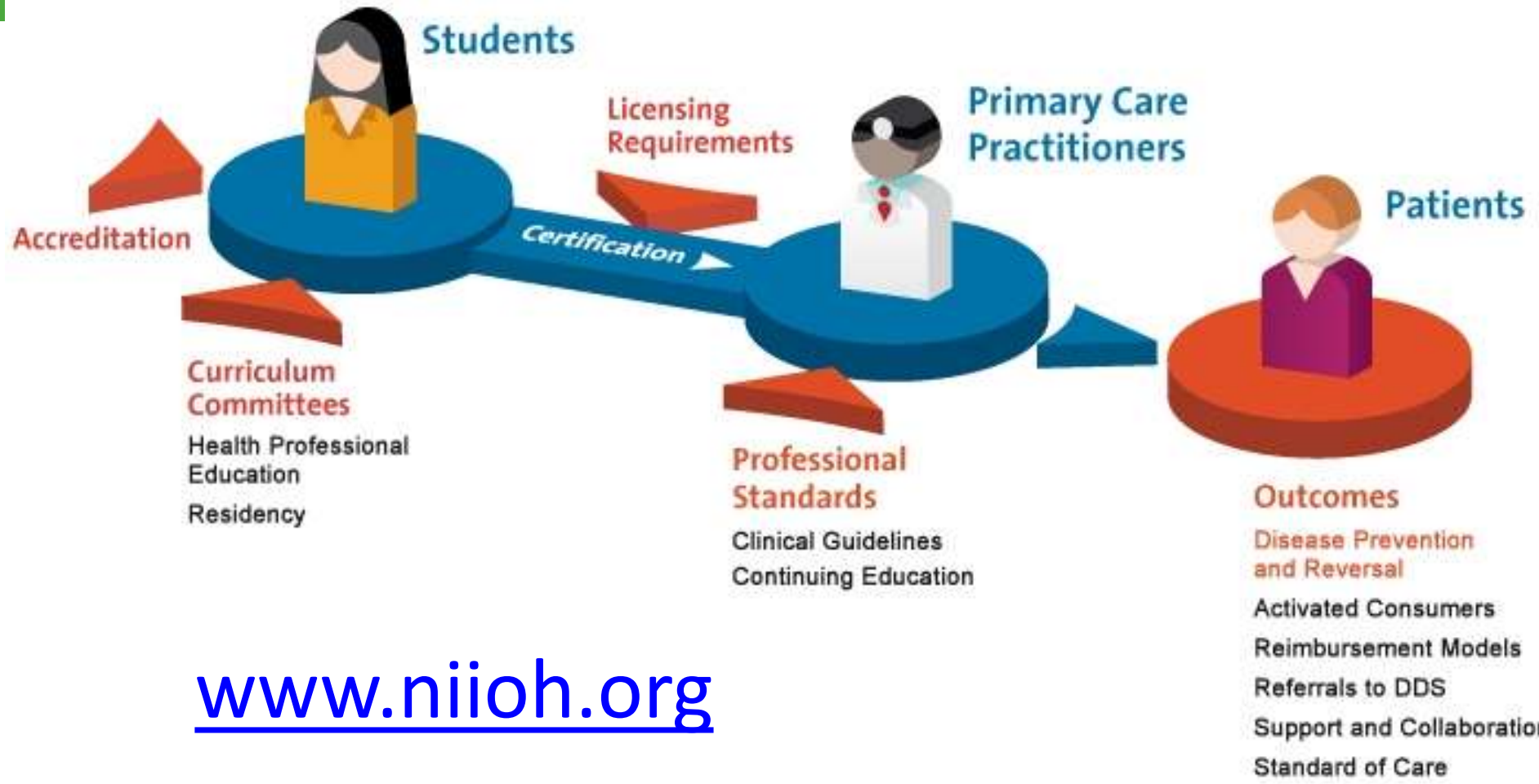
http://www2.aap.org/commpeds/dochs/oralhealth/

One of these things is not like the other



Source: American Academy of Pediatrics, http://www2.aap.org/oralhealth/docs/OralHealthReimbursementChart.xlsx

National Interprofessional Initiative on Oral Health



www.niioh.org

This hour in history needs a dedicated circle of nonconformists. The saving of our world from pending doom will come not from the actions of a conforming majority, but from the creative maladjustment of a dedicated minority.

Martin Luther King, Jr.

Medical/Dental Collaboration

- Treating the patient's dental needs
- Educating the parent and caregiver
- Community water fluoridation

Collaboration & Coordination

- Midwives and Obstetricians
- Pediatricians and Family Practice
  - Well-baby visits
  - Fluoride supplements
  - Fluoride varnish
  - Coordinated referrals
- Pharmacists
- Board of Directors

Collaboration & Coordination

- Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Prenatal Education classes
- Head Start/Early Head Start
- Schools (Parents & Teachers)
- Grandparents in Senior Centers

Educating a Grandma benefits multiple generations

Preaching their gospel…*give and take*

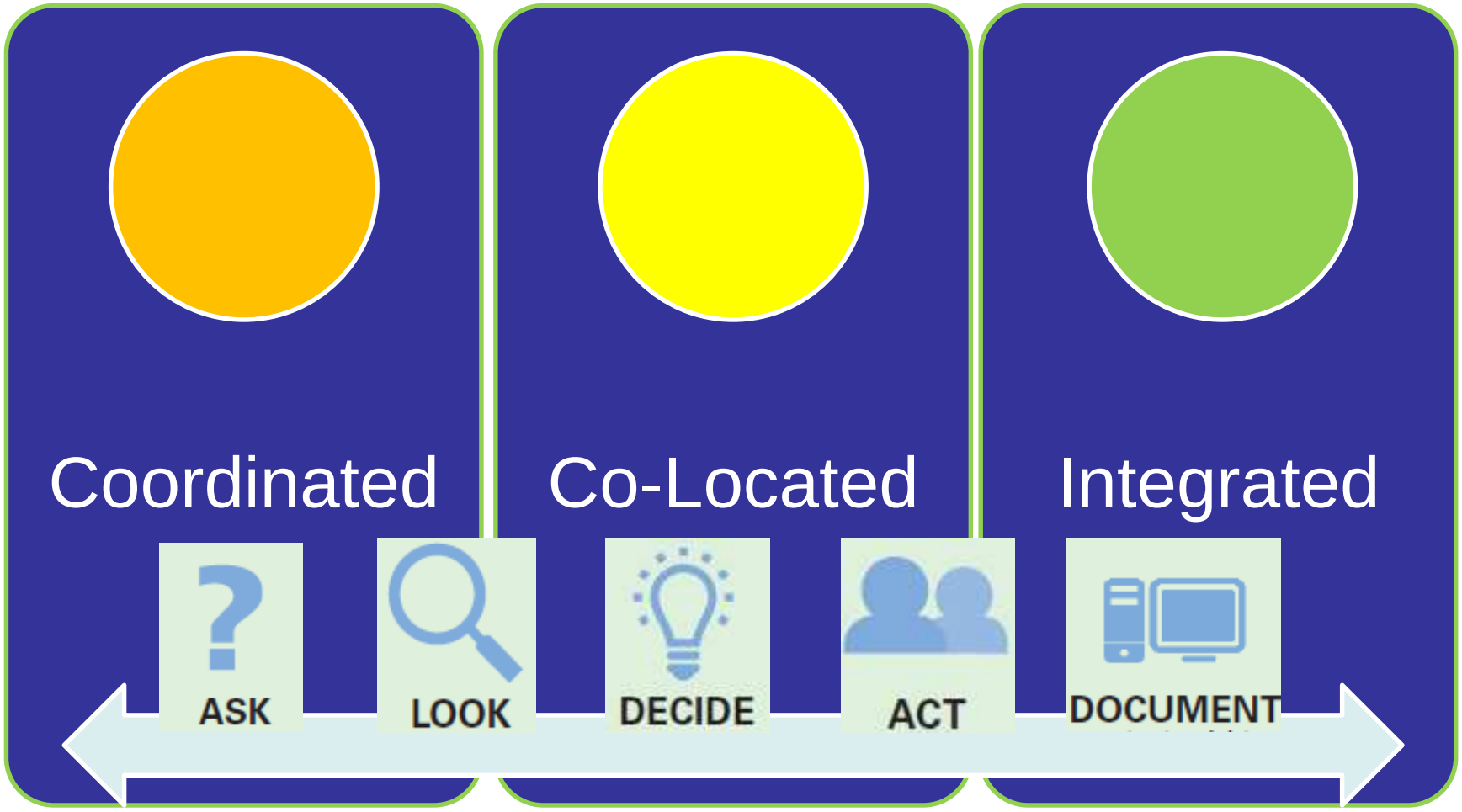
- Prevention Services
  - Mammograms
  - Pap smears
  - Immunizations
  - Hypertension
- Staff education
- Diabetes
- Hygienist in medical home

Bringing Oral Health into the Medical Home

Continuum of Oral Health Promotion in Medical

Coordinated		Co-located		Integrated	
Key Element: Communication		Key Element: Built Space		Key Element: Practice Transformation	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal collaboration	Basic collaboration at a distance	Basic collaboration onsite	Close collaboration onsite with some integrated systems	Close collaboration approaching integrated model	Fully collaboration in transformed practice

Continuum of Oral Health in the Medical Home



Coordinated Care Characteristics

- Core team of medical providers and support staff
- Oral health instruction +/- fluoride varnish
- Coordinated referral to outside dental provider
- Coordinated Referral (informal to formal)

Drive Walk Bus

Co-Located Care Characteristics

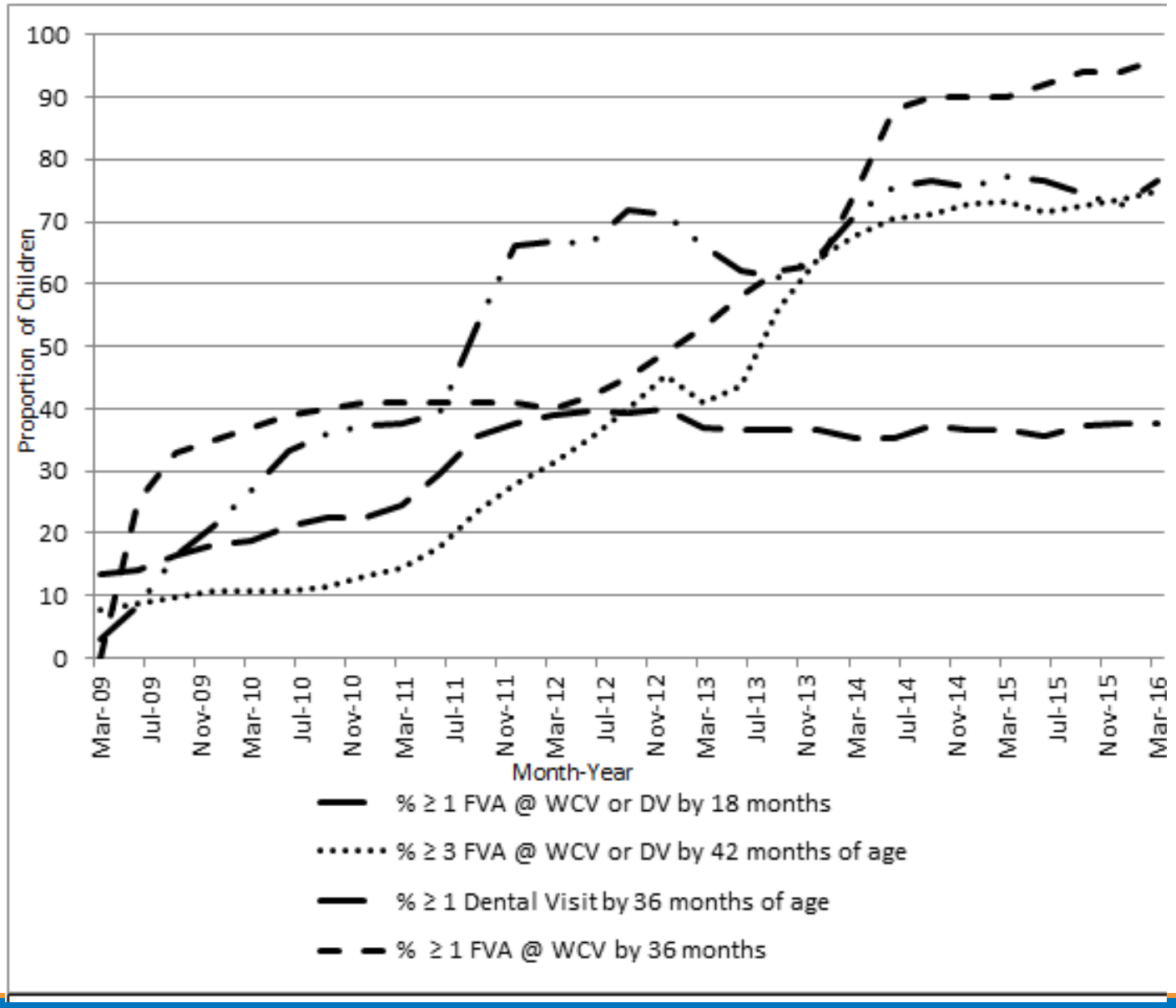
- Core medical team
- Co-located core dental team
- Oral health instruction +/- fluoride varnish
- Coordinated referral to inside dental provider
- Coordinated Referral
  - informal to formal
  - EDR + EMR

Medical-Dental Integration Characteristics

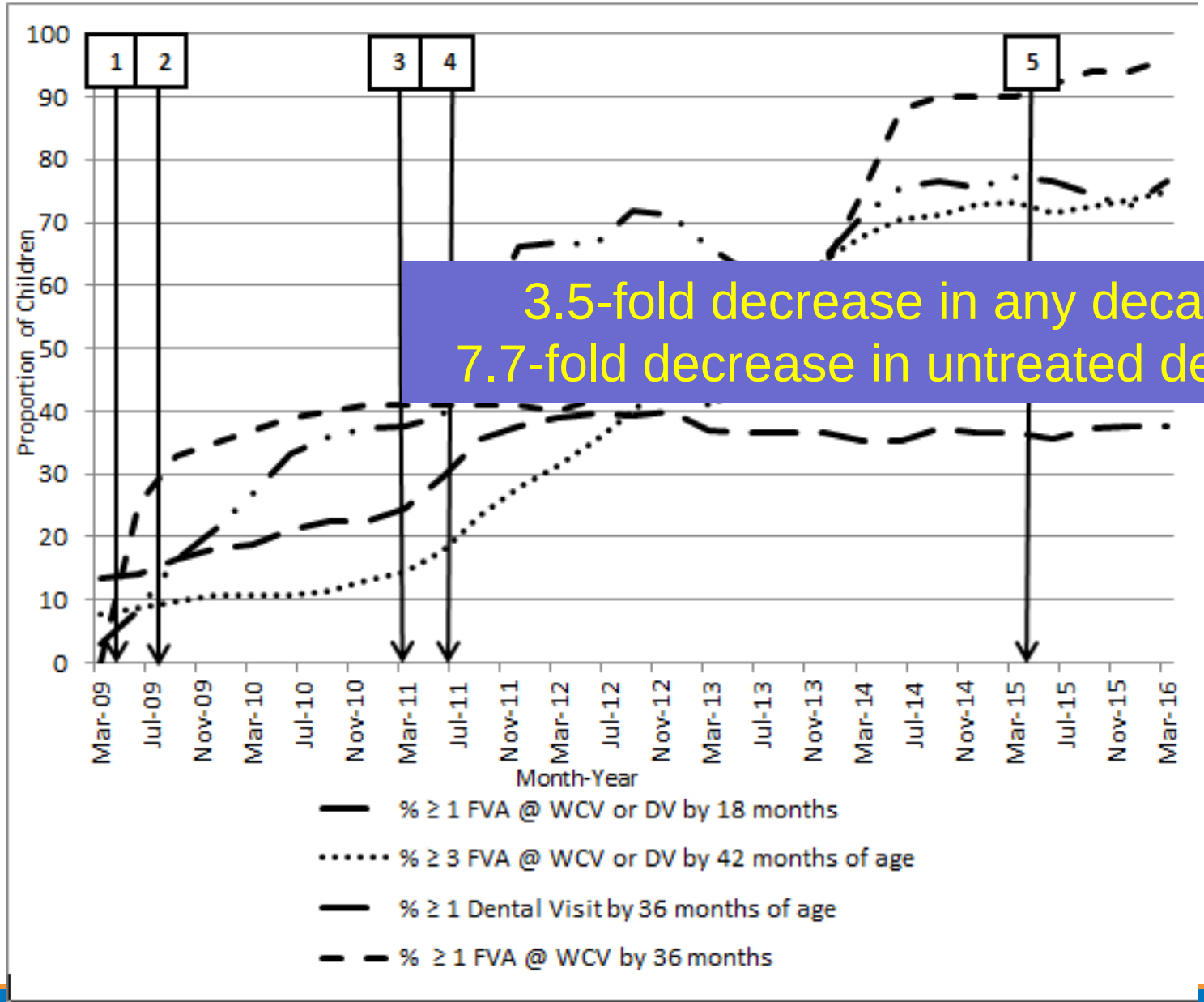
- Core medical team
- Extended team includes dental hygienist
- One-stop shop
- Integrated systems
  - Scheduling, billing, treatment planning
- Case-coordination for restorative services

mdi COLORADO
DELTA DENTAL

Denver Health/Cavity Free at Three…a case study

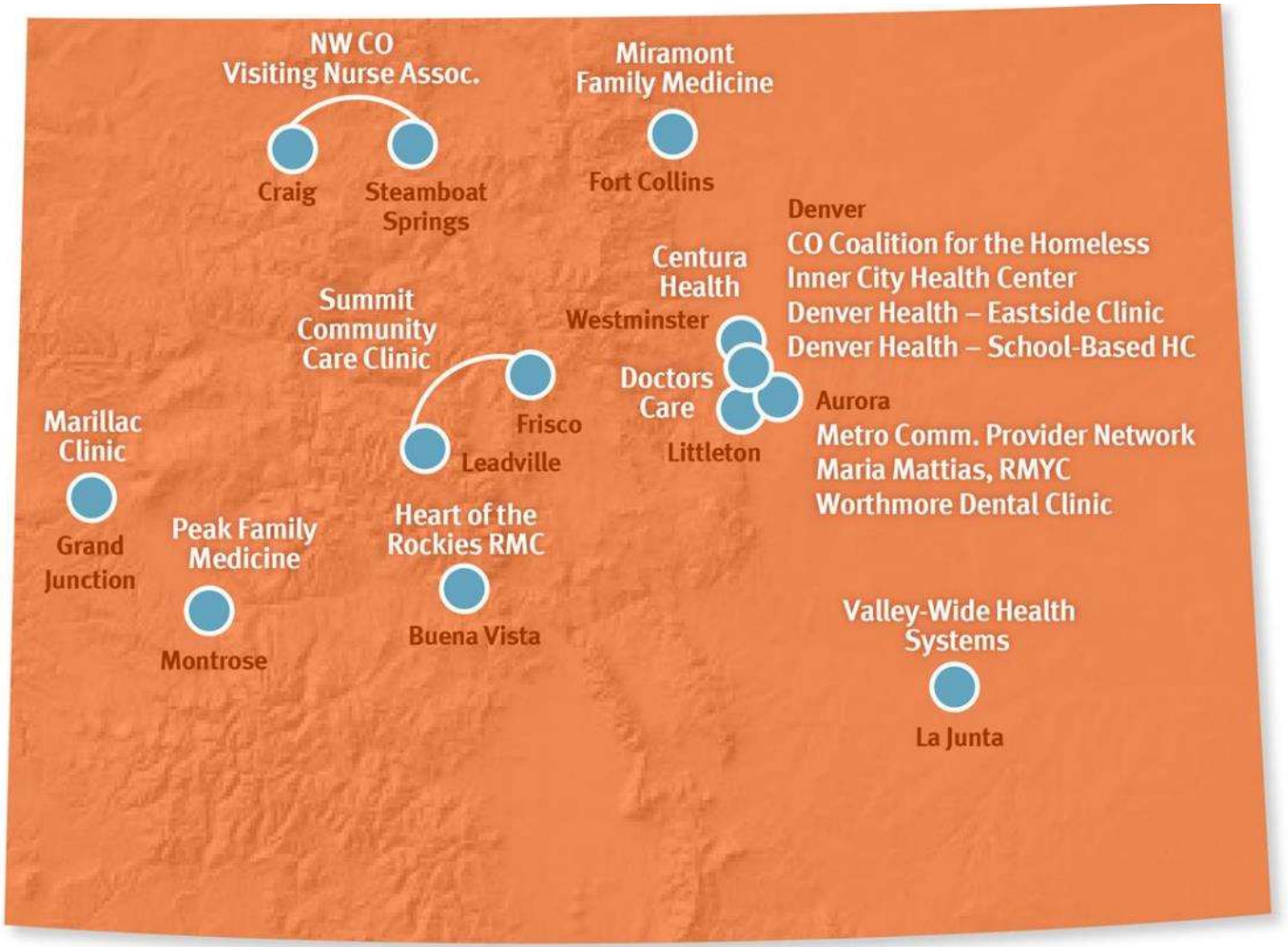


Denver Health/Cavity Free at Three…a case study



3.5-fold decrease in any decay
7.7-fold decrease in untreated decay

Colorado Medical-Dental Integration… a story



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DELTA DENTAL

AAP EQIPP


American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
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Best Sellers
Shop by Topic
Shop by Product
Search by keyword, product name, or product number
Search
Browse by Topics
Adolescent Health
Breastfeeding
Child Abuse and Neglect
Developmental and Behavioral Pediatrics
Genetics and Birth Defects
Infectious Diseases
Nutrition
Obesity
Primary Care
School Health and Child Care
Sports Medicine and Orthopaedics
Online Courses
Meeting Your Learning Needs at Every Stage of Your Career.
Available NOW!
EQIPP Oral Health
Reduce dental caries rates and improve oral health care.


Community Dental Health Coordinator

Engaging the Patient…*go to them!!!*

Community Dental Health Coordinators

- Dental “community health workers” who perform outreach, community education and preventive services
- Dental team members who work in community settings, FQHCs, tribal clinics, senior citizen centers, Head Start programs, religious institutions, and private practices
- A new member of the dental team

Dental Navigators - CDHCs

- Coordinate care - arrange transportation
- Reduce dental anxiety/support access
- Encourage patients to complete treatment
- Educate the population about prevention
- Navigate Medicaid or other dental systems of care
- Enhance productivity and integration of oral health team

Community Health Worker Skills

- Community Mapping
- Motivational Interviewing
- Home Visit Strategies
- Evaluating Credible Data
- Being a “Change Agent”
- Cultural Competence
- Case Management

Training the Next Generation

The value of collaboration…

Individually, we are one drop.
Together, we are an ocean.

— Ryunosuke Satoro
Japanese Poet

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."

-- Margaret Mead

Questions

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